STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pickaway Manor Care Center	391 Clark Drive Circleville, OH 43113

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview, and facility policy review, the facility failed to notify the physician when a resident experienced a significant weight change. This affected one (Resident #76) out of three residents reviewed for nutrition. The census was 75. Findings include: Review of the medical record for Resident #76 revealed Resident #76 was admitted to the facility on [DATE]. Resident #76's diagnoses included but were not limited to unspecified severe protein-calorie malnutrition, chronic kidney disease, pulmonary hypertension, cardiomegaly, congestive heart failure, atrial fibrillation, edema, cardiomyopathy, and hypertension. Review of Resident #76's Minimum Data Set (MDS) assessment, dated 02/03/24, revealed she was cognitively intact. Review of Resident #76's weights revealed she had the following weights recorded: 135 pounds on 01/29/24 , 147.2 pounds on 02/05/24, and 157 pounds on 02/12/24. Review of Resident #76's nutritional notes and documentation, dated 01/29/24 to 02/16/24, revealed no evidence to support the physician was notified of Resident #76's significant weight gain of 12.2 pounds (nine percent [%]) from 01/29/24 to 02/05/24 and significant weight gain of 22 pounds (16.3%) from 01/29/24 to 02/12/24. Interview with Corporate Dietitian #148 on 05/08/24 at 11:25 A.M. and 11:57 A.M. confirmed there was no evidence to support the physician was notified of Resident #76's significant weight gains between 01/29/24 to 02/12/24. Review of the facility Change in Condition Notification policy, dated 08/09/23, revealed the nurse will notify the resident, the resident's physician/practitioner, and the resident's designated representative when there is a significant change in the resident's physical, mental, or psychosocial status or a need to alter the resident's medical treatment significantly.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review and staff interview, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) documents were accurate. This affected one (Resident #56) out of one resident reviewed for PASRR documents. The census was 75. Findings include: Review of the medical record for Resident #56 revealed Resident #56 was admitted to the facility on [DATE]. Resident #56's diagnoses included but were not limited to chronic obstructive pulmonary disease, acute and chronic respiratory failure, cerebral infarction, hemiplegia and hemiparesis, epilepsy, bipolar disorder, major depressive disorder, anxiety disorder, and schizoaffective disorder. Review of Resident #56's Minimum Data Set assessment, dated 04/05/24, revealed she had a severe cognitive impairment. Review of Resident #56's PASRR document, dated 11/14/22, revealed it was completed by another nursing facility. Review of the PASRR document, under Section E, revealed the only diagnoses listed for Resident #56 was panic or other severe anxiety disorder and major depressive disorder. Review of the PASRR document revealed the following diagnoses were not included on the document: bipolar disorder and schizoaffective disorder, which were present upon Resident #56's admission on 02/03/23. Interview with Social Services Coordinator #185 on 05/07/24 at 1:53 P.M. and 2:22 P.M. confirmed the PASRR document dated 11/14/22 was Resident #56's most recent PASRR. She confirmed Resident #56 had diagnoses of bipolar disorder and schizoaffective disorder were not listed on PASRR document from the other nursing facility and no new PASRR was completed for Resident #56 . Interview with Social Services Coordinator #185 on 05/08/24 at 1:15 P.M. revealed she updated Resident #56's PASRR document on 05/07/24 and Resident #56 did trigger for a level II review.

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NAME OF PROVIDER OR SUPPLIER Pickaway Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 391 Clark Drive Circleville, OH 43113	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on medical record review, observations, and staff interview, the facility failed to ensure catheter tubing was stored properly/appropriately to prevent the spread of infection. This affected one (Resident #283) out of one resident reviewed for urinary catheters. The facility census was 75. Findings include: Review of the medical record for Resident #283 revealed an initial admitted [DATE] and a readmitted [DATE]. Resident #283's medical diagnoses included sepsis, obstructive and reflux uropathy, delirium, disorientation, and altered mental status. Review of the care plan, dated 04/19/24, revealed Resident #283 had an indwelling catheter. Interventions included to complete catheter care per facility protocol. Review of the Catheter Evaluation, dated 04/22/24, revealed Resident #283 had an indwelling catheter. Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 04/25/24, revealed Resident #283 had severely impaired cognition and scored a two out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #283 was dependent on staff for toileting and personal hygiene. Resident #283 had an indwelling catheter. Observations on 05/05/24 at 4:10 P.M. and on 05/06/24 at 3:07 P.M. revealed Resident #283 was laying in bed and the catheter tubing was hanging down on the left side of the bed, close to the wall, touching the floor. Observations on 05/07/24 at 10:06 A.M. and 10:09 A.M. revealed Resident #283 was laying in bed and the catheter tubing was hanging down on the left side of the bed, close to the wall, touching the floor mat that had been placed next to the resident's bed. Interview on 05/07/24 at 10:09 A.M. with Licensed Practical Nurse (LPN) #212 confirmed Resident #283's catheter tubing was laying on the floor mat by Resident #283's bed. LPN #212 confirmed the catheter tubing should be stored in a position where it can be kept off the floor and floor mat.